# STATEMENT FOR THE RECORD

of

# THE COMMISSIONED OFFICERS ASSOCIATION of the U.S. PUBLIC HEALTH SERVICE

on

# THE COMMISSIONED CORPS OF THE U.S. PUBLIC HEALTH SERVICE TRANSFORMATION

Presented to the

# HOUSE COMMITTEE ON GOVERNMENT REFORM

## Submitted by:

Captain Gerard M. Farrell, USN (Ret.)
Executive Director
Commissioned Officers Association
of the U.S. Public Health Service

## October 30, 2003

## Captain Gerard M. Farrell, USN (Ret)

Captain Farrell, a thirty-year career naval officer, retired from active duty on 1 July 2000 and was appointed Executive Director of the Commissioned Officers Association of the United States Public Health Service (COA) on 1 November 2001. A Surface Warfare Officer during his Navy career, Captain Farrell served at sea in cruisers and destroyers. He commanded the destroyer, *USS FLETCHER (DD 992)* and cruiser, *USS PRINCETON (CG 59)*. Ashore, CAPT Farrell served in a variety of staff assignments including Chief, Operational Plans Branch, U.S. Pacific Command; Deputy Commandant of Midshipmen at the U.S. Naval Academy; and Commanding Officer, Naval Station Annapolis.

Captain Farrell is a 1970 graduate of the U.S. Naval Academy, and holds a Masters degree in National Security Affairs (Strategic Planning) awarded by the Naval Postgraduate School in 1981. In 1991 he attended the Program for Senior Officials in National Security at the John F. Kennedy School of Government, Harvard University. Captain Farrell's military decorations include the Legion of Merit with two gold stars and various other campaign, unit, and personal awards.

## Commissioned Officers Association of the U.S. Public Health Service

The Commissioned Officers Association (COA) of the U.S. Public Health Service is a professional organization of almost 7000 active duty, reserve, and retired PHS Commissioned Corps officers dedicated to improving the public health of the United States; supporting Corps officers, and advocating for their interests through leadership, education and communication. 70% of active duty PHS Commissioned Officers are members of COA.

# Introduction

The Commissioned Officers Association (COA) of the U.S. Public Health Service appreciates the interest of the House Committee on Government Reform in the important contributions to the health of the Nation by the Commissioned Corps of the U. S. Public Health Service. We thank the Committee for holding this hearing and providing the opportunity to discuss the facts with respect to needed changes for the Corps. In the long and distinguished history of the Commissioned Corps' service to the Nation, its role in defending and advancing the public health has never been more important than now given the evolving and emerging new threats to public health.

The issue under discussion today is the urgency of having a well-run Commissioned Corps due to the increasing severity of health threats to our national security. COA has long advocated for the enhancement of the Nation's public health infrastructure at all levels of government, including an increased role for the PHS Commissioned Corps.[1]

Recognition of the need for an expansion of the responsibilities assigned to the PHS Commissioned Corps and the concomitant imperative to modernize the Corps' administration, management, and operation predates the tragic events in the fall of 2001. The Senate Armed Services Committee, in the Committee Report that accompanied the Department of Defense Authorization Act for Fiscal Year 1999, stated "The Committee notes the efforts underway within the Department

[1] Lord, Michael W., COA Statement for the Record, Testimony before the Senate Health, Education, Labor and Pensions Committee, Subcommittee on Public Health and Safety, March 25, 1999.

of Defense to develop the means to respond to acts of terrorism involving weapons of mass destruction. In this regard, the committee directs the Secretary of Defense to ensure the assessment of needs and capabilities including an analysis of the capabilities that exist within the Commissioned Officer Corps of the U.S. Public Health Service, who, as members of the uniformed services, might be easily integrated into Department of Defense plans to respond to emergencies involving weapons of mass destruction."

The Commissioned Corps has a history of deploying with the military that goes well beyond mobilization in times of war. In such instances the uniform and rank structure of the Commissioned Corps, as noted by the Senate Armed Services Committee, has facilitated the relationship among the services.

Also in 1999 the Senate Appropriations Committee came to a similar conclusion. In the report accompanying the Appropriations Bill for the Departments of Labor, HHS and Education for Fiscal Year 1999, the Committee stated: "In developing plans for bioterrorism countermeasures, the Committee notes the standing personnel and reserves of the Public Health Service are a valuable resource that ought to be well-integrated."

In late 2000, then HHS Secretary Donna Shalala convened a meeting of former Assistant Secretaries for Health to assist in developing recommendations for her successor in the next Administration. Our understanding is those recommendations included a strengthened and expanded Commissioned Corps.

That same group was reconvened in March 2001 by HHS Secretary Tommy Thompson at which time they renewed and updated their recommendations.

The terrorist attacks on September 11, 2001 and the subsequent anthrax attacks in October of that year gave a new urgency to improving the capability of the Corps to respond to these new public health threats. Studies calling for urgent improvements to the Nation's public health infrastructure include a report issued by the Institute of Medicine in November, 2001.[2] Citing the confusion inherent in the federal government's initial response to the anthrax episodes in October 2001, another study addressed the leadership role of the U.S. Surgeon General, which appeared underutilized.[3] Other studies and authors reached similar conclusions.[4] [5]

In a report accompanying the Departments of Labor, Health and Human Services, and Education Appropriations Bill for fiscal 2003, the Senate Committee on Appropriations again signaled support for improvements to the Commissioned Corps, earmarking $2M "for activities related to the transformation and modernization of the Public Health Service (PHS) Commissioned Corps."

[2] "The Future of the Public's Health in the 21st Century, Institute of Medicine, Washington, DC, November 11, 2002.
[3] Rosner, David and Markowitz, Gerald, "September 11 and the Shifting Priorities of Public and Population Health in New York," Milbank Memorial Fund, May 2003.
[4] Kott, Andrea, "Warning: The State of Public Health in America Not So Healthy", *Advances*, The Robert Wood Johnson Foundation, Princeton, NJ, Issue 1, 2002.
[5] Kluger, Jeffrey, "A Public Mess", *TIME*, January 21, 2002

## The Commissioned Corps of the U.S. Public Health Service

The PHS Commissioned Corps traces its origins to 1798 when President John Adams signed an "Act for the Relief of Sick and Disabled Seamen." The Corps was formally established in 1871 during President Grant's administration to correct major management flaws in the hospitals and clinics administered by the Marine Hospital Service. The Marine Hospital Service became the U.S. Public Health Service in 1912. From its inception the Corps was intended as a centralized, mobile, uniformed personnel system whose highly-trained health professionals could be assigned where most needed to carry out the Service's mission. On January 4, 1889, the Congress enacted legislation that formally authorized the Corps.

Throughout our Nation's history, challenges to public health have changed along with the needs of a growing and changing country. The PHS Commissioned Corps has demonstrated a unique adaptability to meet the evolving threat. From a service designed to prevent the importation of disease at our maritime borders, the Corps has progressed through a series of public health challenges including veterans' care following the Civil War and World War I, major public health initiatives incident to the war effort in World War II, and providing health care to Native American populations beginning in the mid-1950s. Along the way, Commissioned Corps officers led in establishing the great public health institutions in this Nation, including the Centers for Disease Control and Prevention (CDC), the Food and Drug Administration (FDA), the National Institutes of Health (NIH), and the Indian Health Service (IHS).

As a uniformed service, the Commissioned Corps brings some unique capabilities to the public health and emergency response arenas, making these officers especially well-suited for the public health response required in the aftermath of a bioterrorism incident. A February 1998 Report prepared by a Special Advisory Committee of esteemed public health professionals headed by Former Surgeon General C. Everett Koop noted, "… expertise which is resident in the Corps to deal with biological and chemical agents is a critical resource that can be called upon in the event of terrorist attack." Tab **A** briefly describes some of the important characteristics of the Commissioned Corps, among them:

- specialized public health training and experience;
- on call **24 hours a day**, like their military counterparts;
- available for assignment to accommodate changing public health needs and priorities;
- an exceptional track record in the area of emergency response;
- presence in all 50 states, with large concentrations of officers in nearly every region of the country, thereby allowing for an expedited response;
- a key role in global health including officers assigned to the World Health Organization and other international public health institutions

The Commissioned Corps is also a rich source of epidemiologists and other professionals whose expertise is critical as part of a bioterrorist response.

A particular strength of the Corps is its diversity. Some 45% of Corps officers are female. 36% of Corps officers are minorities. These percentages are even greater for officers with less than ten years of service reflecting an increasing trend of diversity. These numbers make the PHS Commissioned Corps one of the most diverse entities within the federal government and a role model for the Nation at

large. This composition of the Corps reflects its commitment to what is best for the Nation and the Corps' unique ability to address the needs of the underserved. One special component of the Commissioned Corps is the Commissioned Corps Readiness Force (CCRF), which was created by the Office of the Surgeon General in 1994 to improve the DHHS ability to respond to public health emergencies. The CCRF is a cadre of approximately 2000 active duty PHS officers who are uniquely qualified by virtue of their education, skills and experience to respond to public health emergencies, and who can be mobilized quickly for this purpose.

The Commissioned Corps is also a vital part of the Nation's emergency response capacity through its role with Disaster Medical Assistance Teams (DMATs), which consist of both federal and private sector personnel. One of these DMATs (PHS-1) is comprised primarily of Commissioned Corps Officers (95%). This team has been stationed at high profile national events including, for example, the annual State of the Union Address here in the Capitol to provide the initial public health response in the event of a bioterrorism or other public health incident.

Corps officers have responded to countless public health emergencies. Among the more recent are the Loma Prieta Earthquake (California, 1989), Hurricane Hugo (Virgin Islands, North Carolina, South Carolina, 1989), Hurricane Andrew (Louisiana, Florida, 1992), Milwaukee Water System (Wisconsin, 1993), Midwest Floods (Minnesota, Kansas, North Dakota, Nebraska, Illinois, Wisconsin, 1993-1994), Southwest Flood (Texas, 1993-1994), Northridge Earthquake (California,

1994), Winter Ice Storms (Alabama, Tennessee, Mississippi, 1994), Haitian Immigration (Florida, 1994), California Floods (1994-1995), South East Floods (Georgia, 1994-1995), Oklahoma City Bombing (1995), Tropical Storm Allison (Texas, 2001), World Trade Center Attack (New York, 2001), Pentagon Attack (Virginia, 2001), Anthrax Attacks (Florida, New Jersey, Maryland, Washington D.C., New York, 2001), Avian Influenza Outbreak (Virginia, 2002), Immunization of 19,000 School Children (Washington D.C., 2002), Exotic Newcastle Disease Outbreak (California, Nevada, Arizona, 2003), Midwest Tornadoes (Missouri, Texas, 2003), Smallpox Vaccinations (Maryland, Virginia, 2003), and Hurricane Isabel (North Carolina, Virginia, Washington D.C., Maryland, 2003).

Additionally, Commissioned Corps officers were deployed in the first Gulf War in 1991 and they remain deployed today in Afghanistan and Operation Enduring Freedom in Iraq. Corps officers deployed around the world in response to the SARS outbreak earlier this year.

The Commissioned Corps Inactive Reserve Component has the potential to provide an additional response capacity, or a backfill capacity, as circumstances require, provided it gains the appropriate funding and administrative support.

While the PHS Commissioned Corps is currently the best available source of public health expertise, the organization, administration and operation of the Corps can and must be improved in order to meet the needs of a great variety of

agencies, not all of which are even in the Department of Health and Human Services. In this environment, the Corps is not utilized to its full potential.

## Commissioned Corps Transformation

COA supports what is best for the Nation's public health. We support a strengthened public health infrastructure with an unambiguous chain of command, control, and communications and a clear understanding of who is in charge in a public health emergency. The threat of biological weapons in the war against terrorism demands an army of public health warriors to provide leadership in the Nation's health defense – a most fundamental component of our national security. That uniformed force of health professionals is the PHS Commissioned Corps. Leadership for the Corps and the Nation's public health community is and ought to be provided by the U.S. Surgeon General. Along with improvements in emergency response, we must not forsake more traditional public health threats – many of which overlap with man-made threats emerging today.

There remains a need for public health research and laboratory work to identify, prevent when possible, contain and eventually control diseases. The recent and rapid spread of the SARS virus demonstrated the critical importance of an epidemiological service which can respond quickly and competently. Commissioned Corps officers were rapidly deployed to Asia to assist in efforts to trace the source of this epidemic and contain its spread. Research and laboratory

work are inextricably tied to clinical field work in public health. One of the greatest strengths of our Public Health Service is the cross-cutting relationship among the various disciplines of health professionals in the Commissioned Corps. Another is their ability to move from field work in underserved populations, where the public health risks are greatest, to research work in the course of a career. The vital role of the Commissioned Corps goes beyond its role in the delivery of public health services at the federal level. The Corps is a key element in the Nation's public health infrastructure. The Commissioned Corps is the glue that holds the Public Health Service together.

COA fully supports the DHHS Strategic Plan calling for an "expanded, enhanced and fully deployable Commissioned Corps." We applaud Secretary Thompson's initiative to transform the Corps.

Specifically, COA supports:

- Restoration of authority over and responsibility for the Corps to the Office of the Surgeon General (OSG). This includes budgetary and manpower authority.
- Implementation of a force management system which is billet based and resourced similarly to the other uniformed services.
- An overall recruitment and assignment strategy – one based on the foregoing billet-based force management system. This strategy has as its goal a fully deployable Corps, with improvements to mobility and

emergency response capability, consistent with the needs and requirements of the operating divisions, agencies and departments in which officers are assigned. This includes a robust ready reserve component organized, outfitted, equipped, trained and compensated along the lines of the reserve components of the other uniformed services.

- Initiatives to expand the size of the Corps and enhance its readiness and capability, consistent with the Corps' mission and the goal of increased professionalism.
- Improvements in on-going education including the establishment of a USPHS Academy, designed to increase professionalism.

There are two pillars upon which any organizational transformation, such as sought by HHS for the Corps, will take place. The first is the **organizational structure** itself and the second is the **process** by which the transformation is planned and implemented.

Unity of command is essential to any successful organizational endeavor, whether in the corporate business world or the Department of Defense. This is no less true in public health. For too many years, the headquarters element of the Commissioned Corps was fragmented with the Surgeon General removed from any day-to-day operational authority over the Corps he was supposed to command.

The DHHS plan, as announced by the Secretary and briefed within the Department[6] instead of consolidating the administration and management of the Commissioned Corps under the Office of the Surgeon General, appears to call for yet a further division of authority over the Corps to three separate offices reporting to two different assistant secretaries. The functions assigned to the OSG under this plan; Science and Communications, Commissioned Corps Field Affairs, Force Readiness and Deployment, and Reserve Affairs are either non-existent, undefined, unmanned, unfunded or some combination thereof. This plan effectively sidelines OSG and marginalizes any relationship between that office and the Corps it is supposed to lead. It further fragments the Corps when just the opposite is needed.

COA firmly believes that consistent with sound business practices and principles of efficient organization, **all** functions related to the administration, operation and management of the Commissioned Corps must be aligned under one command unit, and this is most appropriately the Office of the Surgeon General. Specifically, the functions of requirements identification and setting, recruiting, training, assignment, officer support, compensation, and medical affairs must report to the Office of the Surgeon General. Full budgetary and personnel management authority to staff and operate all these functional areas must be provided to OSG. Signature authority for Commissioned Corps Personnel Manual administrative instructions should be retained by the Surgeon General,

[6] USPHS Commissioned Corps Transformation Initiatives – Draft document (Power Point Presentation)– 8/12/03

as is the case with service chiefs in the other uniformed services. Broad regulatory policy should appropriately remain with the Office of the Secretary.

We are especially concerned that authority for the compensation and medical functions has been assigned to the Program Support Center in the office of the DHHS Assistant Secretary for Administration and Management. This separate authority, completely divorced from the rest of the Corps, brings no benefit to the organization and will unnecessarily complicate policy development, force management, communications, and resource allocation. In fact, DHHS has recently proposed substantial changes in the manner by which active duty PHS officers will receive medical care. The proposed transition to a Tricare-based system is likely to have a major negative impact on officers in the Indian Health Service, Bureau of Prisons, and other agencies – including CDC – who are assigned to duty stations that are not near a military medical facility. COA is seeking to work with DHHS on this important issue which could have serious implications for the assignment and retention of officers. We feel strongly that the functions of compensation and medical affairs must come under the direct authority of the Office of the Surgeon General. These are essential components of force management and have a direct impact on the officers needed to carry out their important public health work.

The process by which a strategic transformation is planned and implemented will have direct and lasting impact on the outcome produced. A flawed process will

produce a flawed outcome. Senior officials within HHS have expressed serious reservations about the process by which the transformation is being planned and implemented. COA agrees with these assessments. The reaction of Corps officers, the leadership of our major public health institutions, and members of Congress is evidence enough of the flaws in these plans. A principal reason for this is that the process being used is exactly the reverse of what it should be.

DHHS began this process with a series of action plans – "Decision Orders" - aimed at meeting intuitive challenges. There were vague references to new or evolving roles for the Corps. There was no attempt made to define or determine requirements. COA agrees that the challenges identified by the Department must be addressed. The first step, however, must be a validation of the role and mission of the PHS Commissioned Corps in public health. This cannot be satisfactorily accomplished without including input from the stakeholders in public health. Thoughtful professionals throughout the country with deep commitment to the status of public health in our Nation are concerned about the cloistered development and lack of professional consultation on such a major move as is contemplated for this most valuable national human resource. Former Assistant Secretaries for Health and Surgeons General have expressed their concerns about the organization and process by which much needed changes to the Commissioned Corps are being planned and implemented.[8]

[7] Remarks to CDC "All hands" meeting for Corps officers, 8 October 2003.
[8] Former ASHs Robert Windom and Julius Richmond and former Surgeon General C. Everett Koop. In a letter dated September 10, 2003 Dr. Windom wrote "The ASH and SG are impotent, placed aside by persons who have no interest in PHS. This incompetence must not be allowed to continue, and the PHS must be restored to its previous vitality."

In effect, the Department's approach to transformation resulted in a plan which addressed individual issues in isolation. The totality of the proposals was overlooked and the isolated and exclusionary manner in which decisions were reached led to extremely poor communications with the officers who were most affected. Not only has there been poor communication with Corps officers, but also with the many HHS operating divisions and non-HHS agencies to which officers are assigned. In particular, our understanding is that until recently, the Surgeon General was virtually excluded from the planning process with decisions made in his name during his absence by officials with neither the authority nor the approval of the Surgeon General.

The result is predictable. Plans developed in secrecy and isolation, failure to include or even communicate with those most affected by the outcome, and new policies with the clear intent of penalizing officers in research, laboratory and regulatory assignments and those transferring from other uniformed services have created confusion and discontent. Officers are questioning their career choice and there is growing concern that officers will leave the Corps in significant numbers taking with them the expertise that is so vital to the Nation's public health preparedness at a time when we can least afford to lose it.

Corps officers look to the Surgeon General for leadership just as members of other uniformed services look to their respective service chiefs. The Surgeon General makes every effort to be responsive to Corps officers. Try as he might,

however, in the present environment and under the proposed plans to transform the Corps, the Surgeon General is being prevented from exercising any meaningful leadership authority over the Corps. This situation contravenes the intent of the President in nominating the Surgeon General and the Senate in confirming him.

COA's specific concerns with the results of this flawed process are as follows:

- The DHHS approach implies new roles and missions for the Corps but does not specifically address them. Nor does the plan address existing roles and missions for the Corps which seem to be devalued.
- Force shaping policies have been introduced with no attempt to define the requirement to which the force is being shaped. The promotion policies put forward by the Department will have exactly the opposite effect of intended and are likely to result in a smaller, less capable Commissioned Corps.
- The new policies, since they were decided without input from the operating divisions and agencies, including the non-HHS agencies where officers are assigned, have created a situation where officers are less likely to be employed in these vital public health institutions in the future. One prominent agency head stated his objections to Secretary Thompson in just these terms.[9]

[9] FDA Commissioner letter to DHHS Secretary dated August 15, 2003.

- The proposal to recruit two-year degree nurses as warrant officers has raised significant concerns in the public health community.[10]
- Adequate funding for the transformation and its effective implementation does not appear to have been considered.

Within the last two years, COA's affiliated Foundation has completed two study projects examining recruitment, selection, and assignment policies and procedures used by the Commissioned Corps. The general conclusions and recommendations of these efforts found that, while a Corps-wide recruiting focus is needed, the more urgent problem is in the selection and assignment process. For example, the DHHS transformation plan calls for the recruitment of 1000 two-year degree nurses, yet there are currently over 125 fully qualified and boarded four-year degree nurses seeking a commission in the Corps who are awaiting assignment. These and other force shaping problems can only be resolved by instituting a billet-based requirements and force management process.

One of the challenges that the Department wishes to overcome with this plan is the oft repeated criticism, especially by the Office of Management and Budget, that the Corps is top-heavy. Perhaps the distribution is as it should be. The purpose of the Commissioned Corps is not to provide services that are readily available through contract or temp agencies – it is to defend the public health

[10] Blakency, Barbara, President, American Nurses Association, in a letter to DHHS Secretary Thompson dated 1 August 2003.

using the best expertise at the nation's disposal. That expertise takes time to develop. Once lost, it may take another half-century to reacquire. What is not considered in the superficial analysis which concludes the Corps is top-heavy is any notion of the mission of the PHS Commissioned Corps. Grades of officers must be appropriately matched to their responsibilities consistent with the defined requirements of the billets they occupy in support of mission success. This is not currently done. Once this is accomplished it may well be that the rank structure of the Corps is entirely appropriate. Where it is not, appropriately targeted corrections can be instituted.

We understand there is a draft of proposed legislation being developed within DHHS to implement the transformation. Our information is that the draft proposal contains a provision creating several additional O-9 (three star vice admiral; the rank of the Surgeon General) billets in the Commissioned Corps. One cannot help but wonder why this is even being considered if the drafters of the plan think the Corps is already top heavy.

The unfortunate result of the poorly planned and communicated transformation is an alarming degradation of morale in the Commissioned Corps. COA has received hundreds of comments from members expressing their alarm and concern over the process and direction of transformation. One Corps officer, an eminently qualified medical epidemiologist assigned to CDC where he works in smallpox research was particularly eloquent. He wrote, “In general, the leadership of CDC's disease recognition and response teams has been staffed

through the Commissioned Corps. The "transformation" of the Corps would appear to systematically disassemble such expert teams…." Many of the comments received were mirrored in an article in the New York Daily News on Sunday, October 12, 2003.[11]

This is clearly a crisis for public health at a time when the Nation can ill-afford it.

## Recommendations

Transformation is the term also used in the current approach of the Pentagon to maximize the mobility and effectiveness of valued human resources. As in DoD, the approach must in the public health context as well, consider the broad mission of the Corps to both enhance current mission responsibilities such as health research, evaluation and regulation as well as to prudently prepare for future challenges such as national disaster. COA recommends, therefore, that DHHS adopt a planning process similar to that in use at CDC for its "Futures Initiative." Specifically, we urge:

- A planning process which includes at a minimum input and participation of all DHHS operating divisions and non-DHHS agencies, open and transparent throughout.
- A process which begins with a validation of the mission of the PHS Commissioned Corps and a set of core values to guide the way. The

[11] Kates, Brian, "U.S. Bioterror Plans Ripped", *New York Daily News*, Sunday, October 12, 2003.

validated mission becomes the basis for and drives end strength requirements, recruiting plans and policies, training requirements, assignment (including deployability) policies, promotion plans and policies. In short, mission requirements shape the force. Requirements for Corps officers at the federal, state, and local levels of the public health infrastructure must be included.

- Establishing a billet-based system of requirements identification with the active participation of all affected operating divisions, departments and agencies where Corps officers are assigned. This should include establishing requirements for a ready reserve component.
- Delaying implementation of force shaping policies, including new promotion policies, until the profile of the future Corps can be defined by the requirements based force management system discussed above.
- Confirmation of the role of the Office of the Surgeon General in providing direct leadership, policy administration, management and operational control, including budgetary and personnel management, for the Commissioned Corps.
- Identification by DHHS and appropriation by the Congress of funding to implement the key provisions of a transformed Corps including expansion of the Corps consistent with requirements as defined above , a ready reserve component and a USPHS Academy with scholarship opportunities.
- Clarification of the Surgeon General's role in regard to emergency preparedness within DHHS. This is consistent with the Surgeon

General's role in public health, especially as envisioned by the Department in the transformation process thus far.

Once again, the Commissioned Officers Association very much appreciates this opportunity to submit our views to this distinguished Committee. We look forward to addressing further details of these and other issues with you and the Committee staff.

## TAB A

THE COMMISSIONED CORPS OF THE U.S PUBLIC HEALTH SERVICE

- Is an active duty force of approximately **6000 health care professionals** comprised of physicians, nurses, scientists, dentists, engineers, sanitarians, pharmacists, veterinarians, dieticians, therapists and health services officers who serve in all 50 states and more than 550 locations worldwide.

- Provides officers to serve in the **eight agencies of the Public Health Service**, plus non-PHS agencies including the **U.S. Coast Guard** (whose uniformed medical services are staffed exclusively by Corps officers), **the Federal Bureau of Prisons**, the **EPA**, the **Immigration and Naturalization Service**, and the **Department of Homeland Security**.

- Is one of the seven **uniformed services**, whose members can be called to duty **24 hours a day** to respond to public health crises and emerging needs, and can be **directed** to other duty assignments to accommodate changing public health needs and priorities. In recent years Commissioned Corps officers have been involved in:

  - **Leading** the successful **global campaign to eradicate smallpox**;
  - **Investigating** and **identifying** the emerging **AIDS epidemic**; and the **SARS virus;**
  - **Providing clinical services** for Haitian, Cuban, Southeast Asian, and Kosovar refugees;
  - **Identifying** and **isolating** three separate acute **hemorrhagic fever** viruses in Africa;
  - **Identifying** and **isolating** the infectious agent responsible for the **Hanta Virus** in the American Southwest;
  - **Providing** and **coordinating** emergency services: Oklahoma City bombing ('95); Alaska ('94), California ('94-'95), Southeast ('94-'95), Midwest ('93-'94), Southwest ('92, '93-'94), Northern Plains States ('97) an Ohio ('98) floods; following Hurricanes Hugo ('89), Iniki ('92), Andrew ('92), and Georges ('98); Loma Prieta ('89) and Northridge ('94) earthquakes; following the Northeast ice storms ('98); and in response to terrorist attacks ('01);
  - Providing health care support for the United Nations General Assembly, Secret Service, Capital Police, 2002 Olympic Games, and the Washington, DC public school system.
  - Serving in Afghanistan today and in the First Persian Gulf War in 1991 and in Operation Iraqi Freedom in 2003.